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AUTHOR Kaplan, David M.
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ABSTRACT

This chapter discusses the development of an approach to counseling that allows counselors to incorporate family counseling into their individual counseling practices. The six-stage counseling process that is presented draws upon a broad-based behavior therapy/social learning theory approach. The stages of this process are identified as: establish a relationship; assess the problem; set goals; select an intervention; assess the intervention; and reach closure. This process provides a framework for working with families across counseling specialties while utilizing the professional counseling skills that counselors already possess. (Contains 13 references.) (GCP)

A Process for Working with Families across Counseling Specialties

by

David M. Kaplan

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Chapter Three

A Process for Working With Families Across Counseling Specialties

David M. Kaplan

Like many of you reading this book, I had little graduate coursework that focused on counseling families. I did take a parent-counseling class, but the professor essentially told us for 15 weeks to focus on reflecting and restating, just as one would do in individual Rogerian counseling. I plodded along in the world of one-on-one counseling, doing my best and helping a reasonable number of clients, but there were always clients I couldn't help. What especially bothered me was that with many of these clients, I didn't have a clue what was causing the presenting problem.

My turning point came in 1985 during postgraduate supervision for licensure. I had to pay the going rate (\$65 at the time) for each hour of supervision. After about three weeks and a couple hundred dollars out of my pocket, my supervisor, Dr. Norm Woerle, stated that I knew as much as he did about individual counseling and he felt bad about wasting my money. Norm then asked if he could earn his

fee by teaching me how to work with families. When I agreed, he suggested that I read the classic book *The Family Crucible* (1988) by Augustus Napier and Carl Whitaker. I also began to bring my clients' families into counseling and review their progress in supervision. From that point on, my supervisor earned every penny of his fee. I began to help more clients and to recognize that the etiology of many presenting problems in individual counseling were related to the family dimensions discussed in chapter 2.

I therefore saw the need to develop an approach to counseling that would allow me to incorporate family work into my individual counseling. Two driving forces have shaped this approach. The first is my 14 years in rural private practice. I never knew who would make an appointment or what the presenting problem would be. My clients ran the gamut from adolescent goths flunking out of school to young adults with eating disorders to displaced farmers facing a midlife career change to senior citizens with drinking problems. The second significant factor in developing my counseling approach has been the pragmatic issue that I am not the smartest person in the world. I simply do not have enough space in my brain to have different processes for individual counseling, couples counseling, family counseling, career counseling, substance-abuse counseling, or each type of presenting problem that might appear in my office on any given day. In order to accommodate both of these driving forces, I found it useful to have one counseling process that would accommodate any modality I might be using.

The process I have come to utilize draws upon a broad-based behavior therapy/social learning theory approach. This framework can be summed up in the following paraphrase of what has become known as Paul's Question: How can I take a scientific approach in deciding what works best with this particular client, with this particular problem, with this particular counselor, in this particular setting (Paul, 1967)?

Six-Stage Counseling Process

The following six-stage counseling process allows me to focus on implementing Paul's Question:

1. Establish a relationship
2. Assess the problem
3. Set goals
4. Select an intervention
5. Assess the intervention
6. Reach closure

Note that this six-stage process is not linear. In other words, these are not discrete steps to be started and stopped at given points; rather, they represent your focus at a particular time. Let me give you an example. I was working with a woman in her mid-thirties who was going through a divorce. Her presenting problem was low self-esteem and feelings of worthlessness precipitated by the separation from her husband. Our goal became to increase her feelings of self-efficacy and empowerment. The first five sessions were productive, and my client was well on her way toward increasing her feelings of competency and self-worth. Then I made a mistake. As part of her empowerment, she had opened her first bank account and proudly showed me the design on the checks she had selected. This particular design looked as if a child had scrawled on the check in crayons. Instead of acknowledging the importance of what she had done, I made a flippant remark about how primitive the design looked. I never saw or talked to her again. (She did not return any of my phone calls.) By ignoring the constant need to work on maintaining a relationship, I lost the opportunity to help a client.

The six-step process serves two very useful purposes. First, it allows you the flexibility to go back and forth between individual and family counseling. Thus, you can work with a client individually and bring family members in and out of counseling as appropriate. Second, this process allows you to utilize and build on skills learned in graduate school. Let's review some of these skills.

Establishing a Relationship

Virtually every current approach to counseling says that the very first thing you want to do with a client is to establish a relationship, and there is good reason for that. In a seminal review of outcome research, Lambert (1992) found that 30% of a client's progress in counseling is due to the counselor-client relationship. This finding is so important that I want to repeat it again: *30% of a client's progress in counseling is due to the counselor-client relationship.*

One of the most important things you can do to establish a positive therapeutic environment before a client ever steps into your office is to have an impeccable reputation as an ethical counselor. Scissions (1993) points out that clients do not automatically trust a counselor; trust must be earned. Consistently acting in an ethical manner earns you a reputation as a safe and trustworthy counselor. To paraphrase Will Rogers, I have never met an ethical code I didn't like. The principles of the American Counseling Association and its divisions (i.e., International Association of Marriage and Family Counselors, American Mental Health Association, American School Counselor Association, National Career Development Association, American Rehabilitation Counseling Association) are substantial and well thought-out. The problem is that over the years so much has been added that it is hard to remember everything contained in these increasingly thick documents. Therefore, for my daily routine, I prefer to utilize a distilled and updated version of the framework provided in the ethical code of the American Psychological Association developed in the early 1980s. This framework is easy to remember because it is parsimonious yet thorough. It guides you to act ethically by focusing on eight factors: responsibility, competence, moral and legal issues, public statements, confidentiality, client welfare, professional relationships, and use of assessment instruments.

Responsibility

You have a responsibility to act in a way that causes no harm to any

client. One of the most important aspects of ethical responsibility is informed consent. Clients have the right to know what they are getting into from the very beginning of their counseling experience.

Competence

It is now estimated that 80% of everything we know in counseling becomes obsolete every five years (Kaplan, 1995). If you decide that you paid your dues in graduate school and don't need to learn anything more, your skills become out of date frighteningly fast. Would you go to a physician who is too busy to read any medical journals? Probably not. So it is incumbent upon counselors to stay up to date by maintaining our memberships in professional organizations such as the American Counseling Association and its divisions; attending workshops and conferences; reading books; subscribing to journals and newsletters; and, in general, getting as much information on cutting-edge approaches and techniques as possible. It is not unreasonable to earmark \$500 to \$1,000 per year for professional development activities; this is the price we pay for having the word *professional* in our titles.

Moral and Legal Issues

You have the responsibility to adhere to the morals and rules of your community and institution and to refrain from suggesting that a client engage in any illegal activity. Doing otherwise traps clients between you and their family, their school, their workplace, or the legal system. As an example, let us say that a rehabilitation counselor sees a family that needs help in adjusting to the father's recent blindness caused by glaucoma. A major problem is that Dad is in great pain because of the abnormally high intraocular pressure that occurs with this disease. The counselor has read some research indicating that smoking marijuana may relieve this pressure. It is unethical to suggest that the family go out on the street and find some pot for Dad to smoke because marijuana use is illegal and your intervention may cause harm by leading to an arrest.

A second example revolves around a high school with a written policy stating that all teachers, staff, and administrators must report any student found smoking in school to the principal. If a school counselor finds a student in the bathroom smoking, that counselor cannot make the decision to look the other way because the student is currently in counseling. The policy must be followed and the incident reported to the principal.

Public Statements

Counselors have a responsibility to refrain from conducting impromptu counseling in public when asked for advice. The rationale for this restriction is that in a few minutes on the radio or during a brief conversation at a party or other gathering, you cannot make a thorough assessment or follow up to evaluate the results of your statements and so your advice may cause harm.

Confidentiality

Confidentiality is often referred to as the "cornerstone ethic," for without it we have nothing. Why would anyone tell us anything remotely personal about himself or herself if we might share this information with others? The American Counseling Association ethical standards highlight the need to keep what clients tell us confidential unless there is clear and imminent danger to an individual or when disclosure is required by law. The words *clear* and *imminent* are coupled with *danger* for a deliberate reason; breaking confidentiality, even when appropriate, may cause irreparable damage to your counseling relationships. My first six years of counseling practice were conducted in college counseling centers, and I sometimes think back to an incident that occurred one October night. I was awakened from a sound sleep after midnight by a telephone call from a client. The client stated, "My roommate has been having a contest with his friends to see how long he can stay high on LSD. He has been tripping for about 36 hours and just freaked out, grabbed a knife, and ran into the woods screaming that he is going to kill

himself." Then the student said, " I don't want you to tell anyone about this." Sometimes the decision about whether to break confidentiality is an extremely difficult one, but this was not one of those times. A life clearly needed to be protected, and I immediately called the police and the vice-president of student affairs. A search was conducted, but the police did not find the student until he wandered back home later that day.

Then a funny thing happened. Our counseling center had always had a waiting list for services, with students complaining about the length of time they had to wait for an initial appointment. Suddenly, however, we began to have free slots. Lots of them. Clients were canceling appointments and few students were filling those times. So we did some investigation. Our sources told us the client who had telephoned became very angry that I had called the police because he feared that his stash of drugs would be discovered. Subsequently, my client had started telling every student he knew that the counseling center could not be trusted because the counselors break confidentiality. We had to do a lot of damage control in order to restore our reputation. My point is that if this much damage to the counseling relationship can happen when the responsibility to break confidentiality is so clear-cut, imagine what could happen if we betray a confidence in a more ambiguous situation.

Welfare of the Consumer

We must put our clients' needs before our own. The most frequently raised client welfare issue is the need to refrain from dual relationships. We should avoid being a business partner, teacher, or consultant with any client. Why? There is a risk that the client may become upset at you due to some circumstance in the other relationship (e.g., the person doesn't like the grade you gave, the business decision you made, or the consulting report you submitted). It is unfair to risk souring a counseling relationship because of bad feelings arising from a second relationship with the client.

Due to the potential for extreme damage, a dual relationship that deserves special mention is that of lover. Having sexual relations with a client is a form of selfishness that rivals few others. Clients who have sex with their counselor typically later report that they feel emotionally raped and physically violated. In addition, insurance companies will not cover either lawyers' bills or settlements (which may approach \$1,000,000 with damages for pain and suffering) for counselors convicted of sexual contact with a client. The fact that this is typically the only exclusion in a malpractice policy indicates the severity of the damage that counselor-client sex may cause to the client.

During my five-year tenure as chair of the International Association of Marriage and Family Counselors (IAMFC) ethics committee, I was often asked how long a counselor should wait after closure to engage in a romantic relationship with a former client. The IAMFC code (IAMFC, 1993) states that once an individual has become a client, a counselor should never have a romantic relationship with him or her. The rationale for this provision is that in family counseling, clients often may wish to return to the counselor's office (sometimes years later) to address a variety of individual, couples, and family issues. By engaging in a personal relationship, the counselor denies the client the possibility of returning to a counselor that he or she has grown to trust and respect over time. Other ethical codes are more lenient. The American Counseling Association (ACA) code of ethics (ACA, 1997) states that a minimum of two years must pass before a counselor may have a sexual relationship with a former client. In any case, no matter how attractive a client is, his or her right to obtain quality counseling services is clearly more important than the counselor's need for a date.

Professional Relationships

We have the responsibility to refrain from making disparaging remarks to a client about other mental health professions or professionals. Making negative remarks about the professions of psychiatry, psychology, social work, psychiatric nursing, or the creative art

therapies, for example, can easily come across as arrogant and self-serving. More important, we may cause a client to avoid beneficial services.

Utilization of Assessment Instruments

Professional counselors are trained experts in the use of objective inventories and tests. These instruments aid in counseling and in diagnosis and decision making. As with any powerful tool, testing materials may cause harm if used improperly. The most common problem I have seen is the use of outdated instruments. Commercial tests and inventories are revised periodically in order to maintain current norms, reliability data, and validity data. Keeping up with these revisions is an irritation, even more so when the revised forms, scoring templates, and manual cost from \$50 to more than \$200. There is a temptation, therefore, to save the money and time it takes to purchase and master a revised instrument by continuing to use an expired form. Doing so, however, causes harm because you end up comparing your client against a population that no longer exists, and the information you garner from the outdated instrument is not valid. It is better to have no information about a client than to have psychometrically unsound information. So bite the bullet and use only the current forms of tests and inventories.

Assessing the Problem

Conducting a thorough assessment is as important in family work as it is in individual counseling. One way to utilize the assessment skills that you learned in your graduate counseling program is to conduct what I refer to as a *developmental differential diagnosis* (DDD). The concept of differential diagnosis comes from the field of medicine and refers to the physician's ability to determine what specific disorder is causing the patient's illness through the systematic use of diagnostic techniques. A DDD adapts this process to counseling, in that the counselor lists all possible underlying issues that may be causing or encouraging the presenting problem, then does a thorough follow-up

assessment to determine which issues are most pertinent. As an example, when I have a new client with the presenting problem of anorexia nervosa, three listings immediately go on my DDD. The first is biology. I need to assess whether biological changes are exacerbating psychological problems or putting the client in physical danger. The definition of anorexia focuses on body weight: the disorder occurs when a client is below 80% of ideal body weight as defined by a standard height and weight chart. There is good reason for this biological definition. When individuals fall below 80% of their ideal body weight, they begin to go through physiological changes that can gravely threaten their health. At this low body weight, clients also go through psychological changes. They are unable to think clearly and develop fuzzy thought patterns. As a result, counseling typically becomes ineffective until the client gains enough weight to think clearly. Therefore, if biological factors are ruled in on my DDD, I attend to those first.

The second issue I routinely add to an eating disorder DDD is culture. I need to know how much the societal emphasis on thinness is contributing to my client's anorexia. If cultural norms are making a significant contribution, I incorporate feminist counseling, psychoeducation, and body image techniques into my work with the client. In contrast, if cultural norms are not a significant contributor to the eating disorder, I will not emphasize these approaches at the beginning of my work with the client.

The final listing on my DDD for anorexia is family enmeshment. Enmeshment occurs when family members are so close that individual identity and the ability to direct one's life are thwarted. Children in enmeshed families often feel a lack of control over their lives. They may use food and body weight as focal points to try and regain this control. As one five-foot-six, 92-pound anorexic young woman told me: "If my parents have control over who I date, the school I attend, and the profession I will enter, at least I can control how much I weigh." When enmeshment is ruled in as an item on my DDD, I make sure that family counseling is an integral component of my work with the anorexic client.

How do you add or delete items on your DDD? One effective procedure is to use a primary assessment approach you probably learned about in your graduate counseling program, Arnold Lazarus' (1989) BASIC ID. With this tool you systematically and thoroughly evaluate the following:

Behavior. What client behaviors contribute to, exacerbate, or alleviate the problem?

Affect. What specific emotions does the client feel? What is the client's level of interoceptive awareness (a fancy term for how much people allow themselves to feel their true emotions)?

Sensation. How is the client experiencing and processing the problem through the five senses of sight, sound, smell, taste, and touch?

Imagery. What images form in the client's mind when he or she focuses on the problem?

Cognitions. What specific thoughts go through the client's head when he or she focuses on the problem?

Interpersonal relationships. What are the quantity and quality of the client's relationships with friends, peers, and family?

Drugs/biology. What legal and illegal drugs is the client taking? Do they contribute to or exacerbate the problem?

Do any biological or medical conditions contribute to or exacerbate the problem?

Going through each component of the BASIC ID with a client may greatly assist you in developing your DDD. Substance-abuse counseling with a heroin addict provides an example. Some addicts use heroin primarily because it provides a chemically induced feeling of euphoria that is impossible to replicate by any other means. This issue can be assessed while reviewing sensations, and placing it on your DDD indicates that you need to devise a method for helping the client grieve and deal with the loss of intensely pleasurable physical feelings. Other addicts use heroin because it distracts them from intrapsychic pain. You can assess the amount, intensity, and etiology

of this intrapsychic pain while exploring affect under the BASIC ID. When intrapsychic pain is added to the DDD of a client who would like to kick a heroin addiction, you typically need to incorporate an approach that will allow for the (slow) exploration and remediation of childhood pain and low self-esteem.

You can use a number of additional techniques you learned in graduate school to supplement the BASIC ID when generating a DDD:

Use your knowledge of human development. This is the "developmental" part of a DDD. Because human development is a core part of our professional identity, counselors have a better working knowledge of this field than any other mental health professionals. Ask yourself whether the client's problem is related to a developmental issue or a normal developmental stage. As an example, I would put "empty nest syndrome" as an item to be ruled in or out on my DDD for a 43-year-old female who reports that she started to suffer from depression shortly after her youngest child left for college.

Ask the client. Sometimes we forget to do the obvious and ask what the client thinks is causing the problem. I am amazed how often clients know exactly what their DDD is and what they need to do about it.

Talk to parents, teachers, relatives, and other significant people who have regular contact with your client. These individuals are a rich source of information and often can provide valid hypotheses about the cause and maintenance of the client's problem.

Use inventories and tests. As previously mentioned, instruments are powerful tools that can generate items to add to your DDD. For example, a career counselor may be working with a career indecisive client who has not been able to make an occupational decision despite having enough information about the career decision-making process, different careers, and current opportunities. On administering the *Strong Interest Inventory*, the counselor notices that the client blackened the "indifferent" circle on virtually every work value. Knowing that a large number of blackened "indifferent" circles may

indicate a lack of energy, the counselor may add depression to the client's DDD as an item for further assessment.

Review the professional literature and current research.

Conducting an ERIC or other database search; using an Internet search engine; and reviewing professional journals, newsletters, and workshop notes are all good ways to find out current thoughts about the etiology of a presenting problem. Take advantage of the vast amount of information available, especially when you are presented with a problem you do not see on a regular basis.

Utilize in-house consultation. Present challenging cases at your agency's professional staff meeting and ask for your colleagues' thoughts on items to be added to the client's DDD. Ask for a consultation with a staff counselor who has experience and a good reputation for treating the particular presenting problem that is challenging you. Of course, in-house confidentiality needs to be observed to safeguard client information from leaving your agency or office.

Conduct direct observation. Field observations may provide vital information about the root cause of a presenting problem. Visiting the client's classroom, workplace, or home may be especially useful when the problem is limited to that particular location. For example, I once worked with a disabled veteran with the presenting problem of depression. The client felt that the depression was caused by his inability to accept the need for a wheelchair. One aspect of the depression was that the client was irritable toward his eldest son. Interestingly, the irritability seemed to occur only during mealtimes. So I asked the client to invite me over to dinner. During my observation of the family mealtime dynamics, I noticed that the son kept trying to talk to his dad about an issue, and that the dad was becoming increasingly annoyed and clearly did not want to engage his son in conversation. In our subsequent session, my client acknowledged that he was diverting the conversation. What was he diverting it from? His son had come to the realization that he was

gay and wanted to use mealtimes as an opening to talk to his family about his sexual orientation. The dad was very uncomfortable with the idea of having a homosexual son and wanted no part of the conversation. Because of my dinnertime observation, I was able to narrow down my DDD and determine that my client's irritation was due to issues surrounding his son's sexual orientation rather than his own disability.

Setting Goals

You learned in graduate school that setting goals is an important part of the counseling process for individual counseling. Why? Because as we used to say in the 1960s, "If you don't know where you are going, how are you going to know when you get there?" Goal setting is as important when working with a family as it is in individual counseling. Specific goal-setting issues that arise when a family is in your office will be discussed in chapter 4.

There is debate in the field about the level of specificity necessary when setting goals with clients. Behaviorists gravitate toward specific, concrete, and measurable goals. Counselors with a humanistic perspective may be comfortable with fairly global goals. Focusing on Paul's Question (Paul, 1967) lets us tailor the specificity of goals to the particular client, problem, counselor, and setting. For example, with a smoking-cessation client it may be appropriate to set goals around the number of cigarettes smoked each day. On the other hand, with a client whose goal is self-knowledge, a more general goal of personal growth may be best. In working with families, you will have to make a professional judgment about how specific goal setting should be with each family. There is a balance between making goals concrete enough to ensure a focus on modifying important behaviors yet, as Cavanaugh (1982) states, global enough to generate positive feelings of accomplishment.

Mutuality, a goal-setting skill that you learned in graduate school, will come in quite handy when a family is in your office. Both client and counselor have a right to propose goals. Clients

appreciate the autonomy that comes with choosing the direction of counseling. At the same time, counselors use their expert assessment skills to uncover additional goals that may be fruitful for exploration. Neither counselor nor client has the right to dictate goals, however. A client has the right to decline to pursue a goal the counselor suggests, and counselors may reject a client's goal if it is unethical or unhealthy. For example, a married man made an individual appointment to see me. He said that he was having an affair and consequently feeling guilty. The client then stated that his goal in counseling was to deal with the guilt so that he could enjoy the ongoing affair. I politely stated that I could not agree to this goal, as it was hurtful to his spouse. A second example involved a high school student who came to see me with the goal of improving his grades. After a thorough assessment of the BASIC ID, I noted problems in his family relationships and offered him the opportunity to work as well on being more comfortable around Mom and Dad. The client decided to stick to the academic issue and declined to bring his parents into counseling.

Selecting an Intervention

After you have completed the DDD and goal-setting processes, it is time to select an appropriate intervention. From a broad-based behavior therapy/social learning theory point of view, the first step in choosing an intervention is to select a theoretical framework to anchor your approach (see, e.g., Lazarus & Beutler, 1993). Select a theoretical framework bearing in mind Paul's Question: Based on my thorough assessment, what theory will work best with this particular client, with this particular problem, with this particular counselor, in this particular setting? I encourage you to consider family systems theory (as discussed in chapter 2) as your theoretical framework of choice when a family is involved in counseling.

After selecting a theoretical framework, the next step in selecting an intervention is to choose specific techniques. First, you can select techniques from the anchor theory you have chosen for the particular situation (chapter 6 will focus on approaches from family systems

theory). You can also choose techniques from additional approaches that complement your anchor theoretical framework. This is another area where counselor training pays off. Your theories of counseling class has provided you with a host of different frameworks to add to your arsenal. Many programs use Gerald Corey's *Theory and Practice of Counseling and Psychotherapy* (2001), a text I highly recommend for a review of techniques from the most commonly used theories in counseling. Let us review some of these approaches and some basic ideas about how they can be tied to family work:

Psychodynamic Theory

The psychodynamic approach focuses on developing insight. As such, you may want to use a psychodynamic interpretation when it is therapeutic to link behaviors with needs and motivations. I once worked with an adult child of an alcoholic who had severe fights with her husband. She did not know why she argued with her husband, because otherwise they had a very good marriage. In exploring the timing of these fights, it became clear that they occurred any time the spouse consumed an alcoholic beverage. Even though my client acknowledged that her husband did not have a problem with alcohol, she became afraid and angry because of a hidden fear that he would become abusive just as her dad had done when he drank. Linking the fights with the fear that her husband would act like her father after a drink helped the client to begin the process of understanding that her husband was a different man than her father and would not become violent after having a glass of wine.

Adlerian Theory

Alfred Adler is considered by many to be the father of family counseling. His focus on developing a congruent lifestyle has utility for families that have gotten into a rut where they are behaving in ways that do not promote family unity. For example, when you find that a parent is spending 80 hours each week at the office, you may want to engage him or her in discussions about the impact of this

schedule on the family and whether the workaholism is promoting a healthy lifestyle. Adler also promoted social interest as an important component of mental health. Asking clients to focus on the health of the family rather than individual needs may be useful when selfishness is predominant.

Existential Theory

Existential counseling focuses on helping clients develop a philosophy of life. Existential discussions can be used to help parents cope with the anxieties of child rearing and the fear of death (of self, spouse, and offspring) that comes with the birth of children. Children often reflect the fears of their parents, so it is useful to assess whether a child's problem is a mirror of the anxieties of Mom or Dad. If so, helping the parent work out his or her existential issues will help the child. For example, I was working with a rebellious adolescent who was failing classes. It turned out that her father was a worrier who watched his daughter like a hawk to make sure nothing happened to her. The daughter was feeling suffocated, and her poor school performance was a reaction to this feeling. I spent a number of sessions with the father discussing the existential dilemma of not being able constantly to protect those we love most: our children. Over time, he came to terms with the idea that a parent's role is not to prevent pain but to provide support for his children when the inevitable happens. As he began to change, so did his daughter. As her reason for rebelling was removed, she started doing her schoolwork.

Person-Centered Theory

Rogerian concepts are useful on two fronts. First, they facilitate a conducive counseling relationship. Focusing on unconditional positive regard and the qualities of genuineness, warmth, respect, and empathy may soften the more confrontational family-counseling techniques presented in chapter 6. A thorough and practical detailing of person-centered facilitative approaches can be found in *Intentional Interviewing and Counseling* (1999) by Allen and Mary Ivey.

Second, a person-centered approach works well when you have assessed that a particular client knows the answer to his or her problem. As a general rule of thumb, when both you and the client know the solution to a situation, it is better for the answer to come from the client. Reflection, restatement, active listening, and projecting the qualities listed previously provide a safe counseling environment that allows clients to think through their issues.

Gestalt Theory

In assessing affect under the BASIC ID, you may find that family members have low interoceptive awareness and push down feelings. Gestalt techniques may be useful in such a situation because they focus on bringing emotions into the here and now. When a family is reluctant to acknowledge their feelings in a counseling session, you might use the empty chair; "making the rounds"; the reversal technique; rehearsal and exaggeration exercises; "staying with the feeling"; or focusing on nonverbal messages to bring feelings to the surface (see Corey, 2001, pp. 192–227).

Choice Theory

You might choose to incorporate William Glasser's approach into your work when a family needs a structured approach to healthy decision making. Choice theory is also useful in helping family members assume responsibility for their actions. It has been said that one definition of insanity is doing something that doesn't work over and over again. Choice theory helps family members to sort through what they really want, what they are doing now to fulfill those wants, whether those actions are working, and what different behaviors would be more effective. As an example, I worked with a couple in which the husband was chronically indecisive about whether to pursue a medical degree or a Ph.D. in a social science. His inability to make a decision had caused paralysis to the point where the man had neither held a steady job nor taken any classes for more than 18 months.

Although his wife loved him very much, the resulting stress was causing her to consider divorce. Using choice theory the husband developed two different plans of action. The first was a plan for success involving a step-by-step approach for exploring his academic options and making a decision. The second was a plan for failure listing discrete steps for staying stuck and sabotaging progress. When the husband looked at the two plans side by side, he realized that he had to take responsibility for choosing success or failure. It took him a little while, but he chose the plan for success. He applied to graduate school, was accepted, moved his family 400 miles, and has now almost completed his Ph.D. His family is doing fine and his wife is no longer contemplating divorce.

Behavioral Theories

Behavioral techniques fit into systems theory nicely when a family will benefit from changing specific behaviors. Relaxation exercises, assertiveness training, modeling methods, and operant conditioning may all help shape behaviors that promote a healthy family. I often hear parents complain that their children watch endless hours of television and won't interact with Mom and Dad. I then ask the parents what they do to relax after a hard day's work. Inevitably, the answer is "I watch television." I then suggest that Mom and Dad model the behavior they would like to see in their children by leaving the television turned off in the evening and finding alternate forms of relaxation, preferably ones that allow parent-child interaction. Many parents are willing to follow through on this suggestion, but interestingly a substantial number refuse to do so. Although the need to interact with their children is great, apparently the desire to watch TV is greater.

Cognitive Behavior Theory

Pioneers such as Albert Ellis and Aaron Beck have helped us understand that thoughts greatly influence our moods and actions. The techniques of identifying and correcting irrational beliefs,

catastrophizations, overgeneralizations, and black-and-white thinking may be useful in family work. For example, a mother requested that I work with her tenth grade daughter who showed little respect to her parents. The daughter freely acknowledged talking back to her parents. She explained that she was furious because they expected a correct answer on every question on every test and exam. The girl had brought home a report card with a 97% average that placed her on the honor role. The parents' reaction was to berate her for not having received 100%. In a subsequent session, Mom and Dad acknowledged that they were thoroughly disappointed with the report card. I then asked them what specific thoughts were occurring when they felt this disappointment. Their answer was, "My child must get into an Ivy League college in order to be successful. In order to do so, she has to have perfect grades." I tried to help the parents view these statements as irrational beliefs and black-and-white thinking and to understand the intense stress and anger these thoughts caused in their daughter, which was leading to disrespectful behavior. Unfortunately, the parents were threatened by my cognitive-behavioral approach and withdrew their daughter from counseling until they could find a counselor who, as the mother said, "would fix my daughter instead of jeopardizing her academic success and future happiness." Although I did not have a positive outcome in this situation, it does point out the need to assess the family system instead of assuming that all problems lie within a client.

Assessing the Intervention

An important part of the counseling process is to check out whether your intervention was effective. You might use a number of the techniques discussed in the "Assessing the Problem" section to assess whether your and the client's goals are being met:

Ask the client. As in the assessment stage, we sometimes forget that the client is a useful source of information. I like to ask the following questions on a regular basis:

1. Is our approach working?

2. How can you tell?
3. What have we done that has been helpful in producing change?
4. What have we done that has not been helpful?
5. Are we where you expected to be at this point?

Sometimes I receive an unexpected answer to these questions. I worked with a junior art major who was referred to counseling by the faculty because of signs of depression. After a few sessions I asked whether the counseling was working. The client stated no. I then asked her how she could tell that counseling was not meeting her needs. She replied that she felt less depressed. Confused, I asked her to tell me more. She said, "I thought I wanted to be less depressed. But now that I am, I don't get the dark, creative ideas that drove my work. Give me back my depression so that I can be an artist."

Talk to parents, teachers, relatives, and other significant people who have regular contact with your client. Clients sometimes become frustrated at the slow pace of change, leading to a lack of motivation to continue. Getting regular positive feedback about the changes that are occurring from important people in their life can be a powerful motivating force to continue in counseling. Clients appreciate the pat on the back that comes when family, friends, or colleagues observe that the hard work is paying off. I remember one father who beamed when his wife told him in my office that she noticed and appreciated the fact that he no longer read the newspaper at the table. When I mentioned that I had praised him for his growth but had received a less enthusiastic response, he replied, "I figured that you're a counselor and are supposed to be saying those nice things. This is the first compliment I have received from my wife in ages!"

Use inventories and tests. As mentioned in the "Assessing the Problem" section, objective instruments can be powerful tools for generating a DDD. Another reason to administer an inventory at the beginning of counseling is to provide a baseline of feelings, attitudes, and behaviors related to the presenting problem. This baseline can

be compared with data collected from a second administration of the inventory following intervention. As an example, I worked with a family in which a daughter had chronic low self-esteem. After the first session, the girl completed the *Piers-Harris Children's Self-Concept Scale* (Piers & Harris, 1984). The instrument provided evidence that her issues were focused on her physical appearance and lack of popularity. Both were related to the girl's feeling that she needed to look like a model in order to feel good about herself or for anyone to want to hang out with her. After a number of sessions, once she had started giving herself permission to look like an average girl, I readministered the Piers-Harris CSCS. The results indicated that she now felt just fine about the quantity and quality of her friendships. The physical appearance scale scores had improved, but still indicated that the girl was feeling bad enough about her looks to promote low self-esteem. In exploring her answers to the questions, we found out that the girl was focusing on her crooked teeth. So the parents agreed to get her braces. After her teeth were straightened, the girl reported that she now felt satisfied with her appearance. I administered the Piers-Harris CSCS a third time, and the scores supported the girl's report of positive self-esteem.

Reaching Closure

Counselors used to refer to this final stage of counseling as termination. Then Arnold Schwarzenegger and his *Terminator* movies came along. At that point, it seemed appropriate to change the name to closure.

Closure is easy to overlook because your work on the presenting problem has been completed. Like a metaphorical salesclerk, it is easy to ring the bell and move on to the next customer in line. If you do so, you run the risk that clients and families will feel that they were treated as a problem instead of as people and that you cared only as long as they had a diagnosis. In contrast, spending time and energy on closure gives the message that you are not abandoning the client or family and, in my experience, makes them more likely to

seek out counseling services in the future if needed. I have had clients come back to my office more than four years after closure to work on new concerns. I firmly believe that my attention to the ending of our first counseling relationship significantly influenced their willingness to make a new appointment years down the road. Chapter 8 will focus on specific approaches for successful closure with families.

Conclusion

The process of establishing a relationship, assessing the problem, setting goals, selecting an intervention, assessing the intervention, and reaching closure provides a framework for working with families across counseling specialties. The remainder of this book is devoted to specific ideas and strategies for implementing this process when more than one family member is in your office. It is comforting to note that the skills, theories, and approaches you learned in graduate school provide a firm foundation for implementing the systems-specific ideas presented in upcoming chapters. As such, family counseling need not be a professional area separate from your current specialty. Instead, it is an extension of the professional counseling skills you already possess.

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